

KISD Benefit Change Form 2017-2018

Employee Name:	
Date of Change:	

Employee ID#	
Effective Date :	

FORM WILL NOT BE ACCEPTED AFTER THE 30th DAY OF THE QUALIFYING EVENT

Reason for Change: (Choose One)	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Involuntary Loss of Coverage	<input type="checkbox"/> ON LEAVE FROM DISTRICT
	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Death	<input type="checkbox"/> Employment Status Change	
Documentation: (Choose One)	<input type="checkbox"/> Birth/Death Certificate	<input type="checkbox"/> Proof of Other Coverage	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> Marriage License	<input type="checkbox"/> Divorce Decree		

**PLEASE COMPLETE THE SECTION BELOW ONLY FOR DEPENDENTS YOU WANT TO ADD OR DROP UNDER EACH PLAN.
WRITE ADD OR DROP IN THE APPROPRIATE SPACE BELOW.**

Name (First, Middle Initial, Last)	Social Security Number	Date of Birth	Medical	Dental	Vision	Dependent Life	Cancer	Gender
Spouse								M F
Dependent								M F
Dependent								M F
Dependent								M F
Dependent								M F

Special Instructions:

**All Amounts Shown Are Monthly Premiums
Clearly indicate your Selections**

Medical Coverage			
	ActiveCare 1HD	ActiveCare Select	ActiveCare 2
Employee Only	\$ 40.00	\$ 173.00	\$ 346.00
Employee + Child(ren)	\$ 287.00	\$ 436.00	\$ 654.00
Employee + Spouse	\$ 465.00	\$ 745.00	\$ 1,145.00
Employee + Family	\$ 718.00	\$ 1,018.00	\$ 1,465.00

Waive _____ No Change _____

Regular Leave of Absence RATES (Includes District Portion)			
	Active Care 1HD	Care Select	Active Care 2
Employee Only	\$ 351.00	\$ 514.00	\$ 714.00
Employee + Child(ren)	\$ 671.00	\$ 834.00	\$ 1,062.00
Employee + Spouse	\$ 991.00	\$ 1,264.00	\$ 1,694.00
Employee + Family	\$ 1,316.00	\$ 1,589.00	\$ 2,004.00

Waive _____ No Change _____

Dental Coverage			
	PPO High Plan	DHMO	PPO LOW Plan
Employee Only	\$30.16	\$11.38	\$ 24.22
Employee + Child(ren)	\$73.52	\$23.20	\$ 59.02
Employee + Spouse	\$59.20	\$20.20	\$ 47.52
Employee + Family	\$102.14	\$34.68	\$ 82.00

Waive _____ No Change _____

Vision Coverage	
	Vision
Employee Only	\$ 8.96
Employee + Child(ren)	\$ 14.38
Employee + Spouse	\$ 12.82
Employee + Family	\$ 24.36

Waive _____ No Change _____

Flexible Spending

		Annual Limits				\$2,600.00 Annually if medical coverage with Klein ISD is waived. Contact the Benefits Office for Details
Medical-Health Care	\$ _____	Per Month	(25.00 Per Month Minimum)	Min \$300	Max \$2,600	
Dependent DayCare	\$ _____	Per Month		Min \$300	Max \$5,000	

Waive _____ No Change _____

*** Newly elected coverage will begin the first day of the following month after the date of lost coverage.
Dropped coverage will begin at the end of the month following receipt of this form in the Benefits Office.**

Supplemental Term Life

Employee Age	Spouse Age	Rate
<30	<30	0.047
30 - 34	30 - 34	0.057
35 - 39	35 - 39	0.066
40 - 44	40 - 44	0.085
45 - 49	45 - 49	0.123
50 - 54	50 - 54	0.179
55 - 59	55 - 59	0.255
60 - 64	60 - 64	0.312
65 - 69	65 - 69	0.444
70 - 74	70 - 74	0.916
75 >	75 >	1.888
Child(ren) Life	Rate per Mo.	
\$5,000	\$0.88	
\$10,000	\$1.75	

Coverage: Increments of \$10,000 up to 5X salary or \$500,000 maximum
Employee and Spouse rates are per \$1,000 of coverage per month

Example: A 37 year old elects \$150,000 coverage amount			
150	X	0.066	= \$9.90 per month
(per 1,000 coverage) X		(conversion rate)	Monthly premium

I elect: Employee Term Life Coverage _____

Waive Employee Term Supplemental Life _____

NO CHANGE _____

*** I elect: Spouse Term Life Coverage** _____

Waive Spouse Term Supplemental Life _____

NO CHANGE _____

*** I elect: Child(ren) Term Life Coverage** _____

Waive Child Term Supplemental Life _____

Child(ren) Term Life is Flat rate per month for all children

NO CHANGE _____

** Spouse and Child(ren) coverage can not exceed the employee coverage*

** Changes to Life Coverage may require Medical Underwriting*

Whole Life Insurance

*Information available from the HUB or the Benefits Office

Requested Coverage Amount	Cost
\$ _____	\$ _____

Waive Whole Life _____ NO Change _____

Life Insurance Beneficiary Designation

I hereby request that any payment payable to a beneficiary(ies) after my death in accordance with the life insurance contract and/or the covered plan shall be paid to the beneficiary(ies) listed below. All previous beneficiary designations are cancelled.

This designation includes, and is subject to, the Provisions set by the Life Insurance provider contracted with KISD. This beneficiary designation will be effective for any KISD provided or voluntary Life Insurance plan provided through KISD.

First Name	Last Name	Relationship	% To Pay	Primary or Contingent

Disability Insurance

*See your Benefits Booklet to complete your selection below

Elimination Period	Monthly Benefit	Cost
_____ days	\$ _____	\$ _____

A waiver of elimination period if you are confined in a hospital only apply to the 14/14 or 30/30 elections.

Waive Disability _____ No Change _____

Critical Illness

	Option 1	Option 2
Premiums are age banded and available for all eligible family members	10,000 Benefit	20,000 Benefit
Contact the Benefits Office		

Waive Critical Illness Plan _____ No Change _____

Group Legal Plan

	Rate
Legal Service Only	\$ 15.76
Legal Service & Identity Theft	\$ 25.70

Waive Group Legal _____ No Change _____

I hereby authorize the above changes and amounts to be deducted from my pay.

Signature: _____

Date: _____

Documentation Received By: _____ **Please return completed forms and documentation to the Benefits Office**